Center on Budget and Policy Priorities

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November 18, 2016

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell,

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

Thank you for the opportunity to comment on Illinois' 1115 Behavioral Health Transformation waiver proposal. We support Illinois' demonstration that would strengthen behavioral health services for Medicaid beneficiaries and test intensive efforts to particularly vulnerable populations. We urge CMS to approve this waiver as quickly as possible. Our comments focus on three proposed pilot projects that align with CBPP's work to improve health care services delivered to people with behavioral health conditions with a special focus on those experiencing housing instability and those who are involved with the criminal justice system:

- Supportive housing services that would provide Medicaid coverage for housing-related services;
- Illinois Department of Corrections and Cook County Jail Pilot to improve transitions from prison and jail
- Redesign of the substance use disorder service continuum.

Supportive Housing Services

Illinois is uniquely positioned to test how to use Medicaid funding and service delivery to provide pre-tenancy and tenancy support services for individuals with high behavioral health needs who are at risk of homelessness or inappropriate institutionalization. Supportive housing providers in Chicago have demonstrated that Medicaid expenditures can be reduced by providing housing related services to targeted high cost, high need individuals.[1] A 2009 evaluation of the Chicago program showed that targeting intensive housing support services to people who were high cost Medicaid beneficiaries with histories of homelessness saved the Medicaid program an average of $6,000 a year

[1] Laura S. Sadowski *et al.*, "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults," *Journal of the American Medical Association*, May 2009, Vol. 301, No. 17, pp. 1771-1778.

per person. Illinois now proposes to advance these efforts by including people who at risk of inappropriate institutionalization in the target population. Nursing homes are more expensive than programs that allow people to live independently with appropriate community-based support services so, this pilot is expected to show greater savings in Medicaid expenditures than the 2009 study.

Illinois' waiver request does not include how providers will be selected to carry out this pilot project. CMS should encourage Illinois to make the provider qualification process as simple as possible while ensuring experienced providers are eligible to participate. Given that housing-related services only recently became eligible for Medicaid reimbursement, many behavioral health and social service agencies are not certified as Medicaid providers.

Illinois Department of Corrections/Cook County Jail Pilot

A disproportionate number of people who are incarcerated have mental health and/or substance use disorders, and their incarceration is often directly or indirectly related to inadequate treatment. Linking people to services upon release can reduce re-incarceration rates. Returning Home Ohio, which is similar to the project Illinois is proposing, found that connecting people with histories of repeated incarceration, homelessness and behavioral health disorders to services and housing prior to their release reduced recidivism by 60 percent.[2]

There are specific components of Illinois' pilot proposal that are essential to its success. First, we encourage CMS to approve Illinois' request to allow inmates to maintain Medicaid coverage while they are incarcerated and shift the redetermination process for Medicaid until 90 days after release from jail or prison. This would make it significantly easier and faster for providers to bill Medicaid for services they provide after release. Advances in medication management for mental health and substance use disorders as well as the need for ongoing treatment for other chronic conditions such as HIV/AIDS make it essential that services be available post-release without any gaps in treatment. Illinois' proposal will be a good test of whether maintaining continuous Medicaid coverage instead of suspending or terminating coverage improves care, reduces recidivism and improves administrative efficiency.

Illinois requests waiver authority to auto-assign justice involved individuals into managed care. The waiver proposal explains that the default enrollment process can take more than a month and auto-assignment is faster. While we support enrollment of justice involved individuals into Medicaid, we believe that all individuals should maintain the opportunity to choose a managed care plan or fee-for-service Medicaid where appropriate, and to choose their provider. Corrections system counselors or social service agencies could help inmates choose an MCO and understand what services will be covered upon their release.

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[2] Fontaine, Jocelyn, Douglas Gilchrist-Scott, John Roman, Samuel Taxy, and Caterina Roman, "Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project", Urban Institute Justice Policy Center, August 2012.

We also encourage CMS to work with Illinois to provide adequate social service agency visits with inmates and time to link individuals to services. Illinois' proposal allows providers to begin engaging inmates no earlier than 30 days prior to release and only allows one billable visit. The Returning Home Ohio project found that 30 to 60 days was not enough time to link higher need people to services, especially housing. Similarly, one visit won't be enough for people with the greatest needs. The terms and conditions should provide flexibility to extend the engagement period and number of visits when necessary to engage with inmates and link them to services.

Substance Use Disorder Service Redesign

We strongly support Illinois' proposal to provide comprehensive substance use disorder services and to coordinate those services with mental health and primary care services. The state's proposal is consistent with the July 2015 CMCS guidance encouraging states to develop new service delivery opportunities for individuals with a substance use disorder.[3] While not part of the current proposal, we also support the state's plan to submit a Medicaid Health Home State Plan Amendment to improve care coordination for people with multiple health conditions including behavioral health conditions.

We also support Illinois' proposal to cover residential treatment for up to 30 days for people in fee-for-service Medicaid and managed care. Because the International Classification of Diseases (ICD-9-CM) system classifies substance use disorders as a mental disorder, facilities providing residential treatment are currently considered Institutions of Mental Disease (IMDs). Unfortunately, this classification does not consider that residential treatment is standard care for substance use disorders and is not a similarly restrictive environment as institutions that housed people with mental illness in 1965, when the Medicaid program was enacted. Without Medicaid coverage for residential treatment, beneficiaries have limited options for care and recovery. Low-income individuals with a substance use disorder need the same access to residential treatment as those with moderate and high incomes who can afford residential treatment especially given the opioid epidemic in Illinois. The state reports that between January 2014 and October 2015 there were 2,135 drug related overdoses and almost all of them were due to opioid use.

Finally, CMS should not require that the state cap the number of times people can receive treatment in a residential setting given that people often relapse after exiting treatment.

Thank you for your willingness to consider our comments. If you need additional information, please contact Peggy Bailey (pbailey@cbpp.org).

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[3] CMCS Dear State Medicaid Director Letter, "New Service Delivery Opportunities for Individuals with a Substance Use Disorder," July 2015, https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf.